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Supreme Court of the United States

October Term, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,

Petitioners,

v.

WILLIAM E. SIMON, SECRETARY OF THE TREASURY, *et al.*,

Respondents.

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION

In Opposition to Petition for Writ of Certiorari

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BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION
In Opposition to Petition for Writ of Certiorari

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

This Brief is presented in opposition to the Petition for Writ of Certiorari filed on behalf of Eastern Kentucky Welfare Rights Organizations, et al. (hereinafter "petitioners"), and is directed solely to the substantive issues presented in Reasons 3, 4 and 5 of said Petition. Counsel for both petitioners and respondents have consented to the American Hospital Association's filing of the instant Brief *amicus curiae*.

The American Hospital Association (hereinafter "AHA") is an association whose membership includes

more than 3000 voluntary non-profit hospitals. The interest of AHA in this case arises from the fact that these hospitals are the organizations whose charitable status forms the underlying issue in this case and whose tax-exempt status is determined alternatively under *Revenue Ruling 56-185*, 1956-1 *Cum. Bull.* 202 and *Revenue Ruling 69-545*, 1969-2 *Cum. Bull.* 117. Petitioners are seeking to have the criteria for exemption in the latter ruling declared invalid.

AHA sympathizes with petitioners' concern with adequate health care for the poor. However AHA believes that *Revenue Ruling 69-545*, upheld in the decision below as an alternative criterion for exemption, is correct and will provide more effective access to hospital care for indigent persons than the uncertain, inadministrable and superannuated free care standard advanced by petitioners.

SUMMARY OF ARGUMENT

The underlying issue in this case is the validity of *Revenue Ruling 69-545*. Petitioners' substantive position appears to be that *Revenue Ruling 69-545* is invalid because it allegedly eliminates the requirement that non-profit hospitals must provide "free" care for indigents as a condition to qualifying for tax-exempt status.

AHA respectfully submits that, contrary to petitioners' contention, the instant case does not present an important question of Federal law which should be decided by this Court because *Revenue Ruling 69-545* does not constitute a departure from established Federal policies on health care for the indigent. Both the Ruling and the decision below are consonant with the existing Federal policy of financing hospital care for the poor through reimbursement, as exemplified by Medicare and Medicaid, rather

than of requiring hospitals to provide free, unreimbursed care. Further, the imminent enactment of National Health Insurance with universal coverage will render petitioners' issues moot. Therefore, the issues presented by petitioners are political questions which properly should be, and in fact are being, resolved in the legislative arena.

AHA also respectfully submits that, contrary to petitioners' contention, the decisions of the Court of Appeals for the District of Columbia is not in conflict with decisions of other circuits. No other circuit has ruled on the validity of *Revenue Ruling 69-545* or on the rendition of free care as the sole criterion for tax exemption.

ARGUMENT

I. THERE IS NO IMPORTANT FEDERAL QUESTION FOR THIS COURT TO DECIDE.

A. Tax Exempt Hospitals Must Still Provide Services to Indigents.

The promulgation of *Revenue Ruling 69-545* has not eliminated the requirement for tax exemption of non-profit hospitals that special financial consideration be given to those unable to pay. *Revenue Ruling 69-545* does not supersede *Revenue Ruling 56-185*,[1] but instead provides an alternative method for non-profit hospitals to provide health care for the poor and thereby qualify for exemption. This alternative method requires operation of an emergency room open to all regardless of ability to pay[2] and

[1] This ruling requires, as one of its four criteria, that a tax exempt hospital must be operated to the "extent of its financial ability" for those unable to pay.

[2] The emergency room is usually the principal point of access to hospital care for the poor. As one commentator has noted: "[T]he ambulatory care facilities [i.e., emergency services] of the urban general hospital constitute a major medical care resource for the economically deprived, 'core city', minority population groups." *Medical Care in Transition, American Journal of Public Health*, 414 (1966).

prohibits discrimination against Medicare or Medicaid patients.[3]

Revenue Ruling 69-545 and the decision below provide the poor with more concrete assistance than the vague and subjective "extent of financial ability" standard of *Revenue Ruling* 56-185[4]. Thus, petitioners' assertion that the Ruling and the decision below upholding its validity adversely affect the health care of some 20-40 million poor persons is without substance.

B. The Decision Below Is Not in Conflict with Federal Health Policy.

Petitioners' contention that the decision below is in conflict with a Federal health policy which imposes an obligation on non-profit hospitals to provide free care for the poor is inaccurate. No such Federal policy exists.

The Federal government has long recognized the importance of adequate health care for each individual. However, Federal policy is directed toward achieving this goal by providing reimbursement for health services for persons unable to pay, rather than by imposing an obligation upon health care providers to supply free care. Medicare and Medicaid (42 U.S.C. §1395-1396) provide the clearest and most significant expression of this Federal policy of reimbursement, rather than free care.

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[3] Because hospitals often receive less than actual cost for Medicaid patients, the prohibition against discrimination toward Medicaid patients is a significant benefit to the poor. *See* Idaho Corp. of Benedictine Sisters v. Marks, Civ. No. 1-72-169 (D. Idaho, filed Aug. 29, 1973).

[4] As stated by the District of Columbia Circuit: "Thus, to qualify as a tax-exempt charitable organization, a hospital must still provide services to indigents . . . In the final analysis, *Revenue Ruling* 69-545 may be of greater benefit to the poor than its predecessor Ruling 56-185." Petitioners' App. at 26a-27a.

The various legislative proposals for National Health Insurance introduced during the 93rd and 94th Congress further illustrate the Federal reimbursement policy. None of these bills contain any obligation on the part of hospitals to provide free care. They do, however, recognize that the Federal government should guarantee adequate health care for all by assuming the cost of health insurance for those unable to pay.[5]

As evidence of an alleged Federal free care policy, petitioners refer to the obligation to provide indigent care imposed upon recipients of construction grants under the Hill-Burton program and its successor, the National Health Planning and Resources Development Act of 1974 (collectively the "Hill-Burton Program"). However, rather than being evidence of petitioners' free care policy, the Hill-Burton Program is in effect a further example of Federal reimbursement policy. As under Medicare and Medicaid, the Federal government is really purchasing services for the poor, although under the Hill-Burton Program payments are made in advance of, rather than subsequent to, the rendition of services.[6]

In any event, grants made under the Hill-Burton Program represent only a small part of the government's overall health program. A comparison of (1) government expenditures for reimbursement to health care providers

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[5] During 1974, extensive hearings were held by the House Committee on Ways and Means on National Health Insurance and numerous bills providing for such legislation were introduced during the 93rd Congress. The highlights of these bills are set forth in the Appendix attached hereto. The major proposals, H. R. 1, 94th Cong. 1st Sess. (1975) (the Ullman Bill) and S. 3, 94th Cong. 1st Sess. (1975) (the Kennedy-Griffiths Bill), have been reintroduced in the 94th Congress.

[6] This obligation to provide a reasonable volume of services to persons unable to pay has been held to be a contractural obligation arising out of the receipt of Federal funds under the Hill-Burton Program. Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972).

under Medicare and Medicaid to (2) amounts expended under the Hill-Burton Program evidences an overwhelming commitment to a Federal reimbursement policy. For example, in 1974 the Federal government spent *125 times more on reimbursement* for health services than it spent on grants under the Hill-Burton Program.[7]

C. The Enactment of National Health Insurance Will Render the Issues Moot.

The imminent enactment of National Health Insurance further illustrates the inappropriateness of the issues petitioners are seeking this Court to review. All major proposals for National Health Insurance provide universal coverage enabling all Americans to obtain health care when required regardless of ability to pay. Public statements by Congressional leaders indicate that passage of some form of National Health Insurance will occur during the 94th Congress.[8]

The enactment of National Health Insurance legislation will completely moot the issues raised by petitioners.

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[7] In 1974 government spent $11,321,900,000 on Medicare payments and $11,218,400,000 on Medicaid payments, for a total expenditure of $22,540,300,000. Worthington, *National Health Expenditures: 1929-1974*, SOCIAL SECURITY BULL. Table 3 (1975). On the other hand, government appropriations for hospital facilities construction under Hill-Burton Programs during 1974 were only $120,000,000. *U.S. Dept. of H.E.W., Public Health Services, Health Facilities Construction: By Type of Funds (1920-1974) (Hill-Burton Federal Grants).*

[8] Ways and Means Chairman Al Ullman (D. Calif.) has recently predicted that: "This has to be the year for national health insurance." 5 NATIONAL HEALTH INSURANCE REPORTS, No. 3 (1975); WASHINGTON REPORT ON MEDICINE & HEALTH, No. 1442 (Feb. 17, 1975). *See* to the same effect, statements of Sen. Russell Long (D. La.), Chairman of the Senate Finance Committee, and Hon. Dan Rostenkowski (D. Ill.), Chairman of the Ways and Means Sub-Committee on Health reported in WASHINGTON REPORT ON MEDICINE AND HEALTH, No. 1442 (Feb. 17, 1975).

Under such a program all persons would be covered by health insurance, and thus the need for any free care would be eliminated.

D. Petitioners' Multiplicity Argument Is Without Merit.

No multiplicity of lawsuits will result if the Court denies certiorari in this case. In the first place, the enactment of National Health Insurance will prevent proliferation of litigation on the issues presented herein. Although petitioners assert that "unemployment with its consequential loss of health insurance coverage" will exacerbate the need for free care and encourage further litigation, the expected passage of the Emergency Health Insurance Extension Act[9] to benefit unemployed workers should avoid such result.

In the second place, the commencement of the two lawsuits cited by petitioners in the 5½ years since the publication of Revenue Ruling 69-545 would hardly indicate an opening of the flood gates.[10] The dearth of litigation against the more than 3,000 tax exempt hospitals casts serious doubt upon petitioners' claim as to the importance of the issues presented and prediction of an anticipated multiplicity of lawsuits. Moreover, a decision on the merits herein would not resolve the issues raised in the two cases cited by petitioners.[11]

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[9] H.R. 5000, 94th Congress, First Session.

[10] Petitioners' Petition at 18 n. 15. Lugo, et al. v. Simon, et al., Civ. 74-345, N.D. Ohio; Chapman, et al. v. Berkshire Medical Center, et al., Civ. 74-1954F, D. Mass.

[11] The outcome of these cases would remain unresolved because the question of whether defendant hospitals are operating "to the extent of their financial ability" for those unable to pay under the alternate test of *Revenue Ruling 56-185* would be unaffected by a decision herein.

II. THERE IS NO CONFLICT.

A. There Is No Conflict of Decisions Between Circuits.

Petitioners assert that the decision below "conflicts with the principles set forth in every federal and tax court decision on the subject decided since 1942." Petitioners apparently are not contending, and indeed cannot in good faith contend, that the decision below is "in conflict with the decision of another court of appeals on the same matter." There are no Federal decisions, except the reversed District Court decision below, which have held that Ruling invalid.

B. There Is No Conflict in Established Principles.

Unable to assert a direct conflict between circuits, petitioners attempt to extrapolate a conflict argument by asserting a conflict between the principles underlying the decision below and general principles enunciated in other decisions. This assertion is incorrect.

1. The Lower Court Decision Does Not Eliminate Indigent Care.

The decision below does not depart from prior case law requiring tax exempt hospitals to give special financial consideration to the poor. As indicated above, the decision below properly recognizes that *Revenue Ruling 69-545* provides meaningful criteria for insuring responsiveness to the needs of the poor. The requirements for providing emergency room care to all regardless of ability to pay and accepting Medicare and Medicaid patients are not only compatible with the concern for the poor expressed in existing case law, but provide more concrete assistance to them than the vague and subjective "extent of financial

ability" standard of *Revenue Ruling 56-185* or the "special financial consideration" rule enunciated by the District Court below.

2. The Definition Of Charity Encompasses Social And Economic Change.

The term "charitable" as used in section 501 (c) (3) of the Internal Revenue Code of 1954, 26 U.S.C. §501(c) (3), must be interpreted in its generally accepted legal sense.[12] A basic principle in the law of charity is that ". . . the differing condition, character and wants of communities and nations, change and enlarge the scope of charity, and where new necessities are created, new charitable uses must be established.[13]

By placing reliance on cases decided between 1942 and 1945, petitioners have ignored the existence of major changes in the delivery of health care in the United States, which must be taken into consideration in formulating criteria for tax exemption of today's hospitals.[14] However,

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[12] Treas. Reg. §1.501 (c) (3)-1(d) (2) (1959); Green v. Connolly, 330 F.Supp. 1150, 1157, 1158-59 (D. D.C.), *aff'd per curiam sub nom.* Coit v. Green, 404 U.S. 997 (1971); Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 131 F.2d 337 (D.C. Cir. 1932).

[13] Int'l Reform Fed'n v. Dist. Unemployment Comp. Bd., 46 F.2d 855, 865 (7th Cir. 1931); Green v. Connolly, 330 F.Supp. 1150, 1158-59 (D.C. Cir. 1971); BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 369 (2d Ed. 1964).

[14] In 1940, out of a civilian population of 131,669,000, approximately 12,312,000 persons, or 9.4% of the population were covered by some form of health insurance. U.S. BUREAU OF CENSUS, DEPT. OF COMMERCE, CURRENT POPULATION REPORTS, Series P-60, No. 81; SOURCE BOOK OF HEALTH INSURANCE 1971, at 16. (Health Insurance Inst., N.Y. 1971). However, by 1971, out of a civilian population of 201,000,000, approximately 188,513,000 persons or 92% of the population were covered by some form of health insurance. SOURCE BOOK OF HEALTH INSURANCE 1972-1973 at 17-20. (Health Insurance Inst. N.Y. 1973). Persons eligible for Medicaid are not included in these statistics and, therefore, a substantial percentage of the portion of those listed as not covered were actually provided with protection.

the Court of Appeals for the District of Columbia rejected petitioners' attempt to render the law of charity stagnant by concluding that the means by which a tax exempt hospital serves the poor is not immutable, but must be varied to conform to important economic and social changes in the financing of health care and in government policy.

3. Other Cases Dealing With Private Benefit Are Distinguishable.

Although petitioners cite a number of cases purportedly standing for the rule that the rendition of free care is the *sine qua non* for tax exemption of non-profit hospitals, the actual issue in each of those cases was whether hospitals were operated for the private benefit of a limited number of individuals.[15] A basic principle in the law of charity is that in determining exempt status the test is not whether the patients of a hospital pay more or less for their services, but whether those charged with its operations are conducting it for their private profit or advantage.[16] The absence of a program for charitable care may be strong evidence of the existence of private benefit,[17] but no Federal case has ever denied exemption exclusively on the grounds that a non-profit hospital, which is free of the

[15] Section 501(c)(3) limits charitable exemption to organizations, "no part of the net earnings of which inure to the benefit of any private shareholder or individuals . . ." *See also* Treas. Reg. §1.501(c)(3)-1(d)(1)(ii) 1959.

[16] IV A. Scott, The Law of Trusts §372.1 (3d Ed. 1967); Bogert, The Law of Trusts and Trustees (2d Ed. 1964); 15 Am. Jur. 2d *Charities* §148.

[17] Harding Hospital v. United States, 505 F.2d 1068 (6th Cir. 1974); Sonora Community Hospital, 46 T.C. 519 (1966) aff'd per curiam, 397 F.2d 814 (9th Cir. 1968); Lorain Avenue Clinic, 31 T.C. 141 (1958).

taint of private profit, did not render enough free care to qualify under section 501(c)(3).[18]

Petitioners' attempt to construct a conflict in decision is thus unavailing. There is no conflict between circuits, either directly or in principle. Further, *Revenue Ruling 69-545*, rather than being in conflict with prior decisions and earlier rulings, is compatible with them by conforming the criteria for charitable exemption to social policy and economic changes in the financing of health care for the poor.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the Petitioner for Writ of Certiorari should be denied.

Respectfully submitted,

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[18] In Comm'r v. Battle Creek, 126 F.2d 405 (5th Cir. 1942), cited by petitioners as in conflict with the lower court decision, the issue adjudicated was whether an organization incorporated under the General Corporation Laws of Florida, rather than under Non-profit Organization Laws, and authorized to conduct any lawful business, could qualify under the "organizational test" of section 501(c)(3).

APPENDIX

Reproduction of Appendix A from Comparative Analysis of Four Major National Health Insurance Plans Before the 93rd Congress, Prepared by the Interreligious Task Force on Health Care, June, 1974.

(Attached)

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Appendix A—Major National Health Insurance Plans

	National Health Care Services Reorganization and Financing Act H.R. 1 Ullman	The Health Security Act S. 3 H.R. 22 Kennedy Griffiths Corman
CONSUMER PARTICIPATION	"Equitable" consumer representation on health care corporation boards as well as on the national and state advisory councils.	Provision for consumers in an advisory capacity in policy development and administration of program. Appointed at national, state, local levels.
COMPREHENSIVE COVERAGE	Up to 90 days of hospital care; 10 visits to a doctor per year; 80% of cost of ancillary services, appliances, ambulances, up to 90 days in a nursing home; drugs; up to 45 days in hospital for mental illness, alcoholism or drug abuse, preventive care checkups, well-baby care; dentistry to age 7, vision services to age 12; home health.	Nearly the whole range of personal health care services. All hospital and doctor bills, ancillary services (such as X-ray, lab tests, drugs provided in the HMO); up to 120 days in a skilled nursing home, up to 45 days in hospital for mental illness, medical appliances (eyeglasses, hearing aids, artificial limbs, pacemakers, etc.); ambulances, dentistry for children under 15 years; some outpatient psychiatric care; vision services; some drugs.
POSITIVE HEALTH CONCEPT	Health care corporations—community-based, non-profit organizations capable of providing comprehensive health services in a given geographic area—HCC's charged with health education of membership.	Health Maintenance Organizations (HMO's) required to furnish or arrange for all covered services except mental health and dental services. Emphasis on preventive medicine, early diagnosis of illness, and medical rehabilitation.
FINANCING: **Trust Fund;** **Progressive Tax Based on Ability to Pay;** **No Deductibles**	Payroll taxes and general tax revenues pay for care for aged; general revenues pay for care for the poor. Employer and employees share premiums for group plans on 75-25 basis. Deductibles: $2 per doctor visit; $5 per day for hospital care; $2.50 a day for nursing home care; 20% cost of ancillary services, appliances and most other covered items; $1 per drug prescription. Advisory Council directed to give consideration of national trust fund to supply supplemental capital.	Establishes health security trust fund. Fifty percent of funds from: 1) a 3.5% tax on employers' payroll; 2) a 1% tax on employees' wages and on unearned income up to $15,000 a year; 3) a 2.5% on self-employed income up to $15,000 a year. The other fifty percent from federal general revenues. No deductibles.
ACCESS TO HEALTH CARE AS EVERY PERSON'S RIGHT	A new federal Department of Health would contract with insurance companies and non-profit HCC's for medical services to the poor and aged. Insurance for others under group and individual private plans would have to meet standards set by bill. State health commissions established.	Explicitly stated. All residents of the United States would be eligible for benefits. A new federal agency, the Health Security Board and National Health Security Advisory Council will administer the program and replace all private health insurance plans.
PROVISION FOR QUALITY CARE	Department of Health prescribed quality standards; state health commission regulates peer review systems.	Establishes a commission on the quality of health care, which would develop and enforce national standards for participation both by individual and institutional providers.
PERSONNEL DEVELOPMENT/ DEPLOYMENT: **Manpower** **Research** **Facilities**	Secretary of Department of Health shall make a continuing study.	Would actively encourage more efficient organization of existing health manpower and would provide funds for special training of health professionals and allied personnel. Establishes a resources development fund. Establishment of regional and health services areas.

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Appendix A--Major National Health Insurance Plans(Con'td.)

	Medicredit S. 444 H.R. 2222 HANSEN BROYHILL FULTON	Comprehensive National Health Insurance Act S. 3286 H.R. 3870 KENNEDY MILLS
CONSUMER PARTICIPATION	None—only two representatives of the general public on a National Health Insurance Advisory Board of 11 members.	"Advisory" Councils established; only one of which has a required majority of consumers. All utilization review controlled by providers or medical societies.
COMPREHENSIVE COVERAGE	Hospital bills for 60 days; 80¢ of doctor bills, ancillary services, home health care, ambulances, dentistry for children ages 2-6; 120 days of skilled nursing home care; preventive care and checkups; well-baby care.	*Unlimited*—in-patient hospital and physician services, medical and and other health services. *Limited*—home health services (100 visits per year), post-hospital extended care (100 days per year), out-patient drugs and biologicals (specific chronic conditions only), mental health services (30 days), and preventive care for most children's services.
POSITIVE HEALTH CONCEPT	No positive health concept.	Very little positive health in this bill. Preventive care for children's vision, dental and hearing check-ups. Pre-natal, well baby care and family planning services. All other care is episodic in nature and intent.
FINANCING: **Trust Fund;** **Progressive Tax Based on Ability to Pay;** **No Deductibles**	Trust fund created for those with no federal income tax liability; insurance premium for everyone else under 65. Deductibles: $50 toward each hospital or nursing home stay; 20¢ of the cost of the doctor bill and other covered services.	National Health Insurance Trust Fund to be established from: 1) a 1¢ tax on employees' wages; 2) a 3¢ tax on employers' payroll; 3) a 2½¢ tax on unearned income. *Deductibles*: $150.00 per year-limit of 2 per family. *Co-insurance*: 25¢ on all covered services past the deductible. Out-patient drug co-insurance is $1.00 per prescription. *Limit*: $1,000.00 per year. Built in protection for low income persons. $6.00 premium for long-term care—paid from benefits.
ACCESS TO HEALTH CARE AS EVERY PERSON'S RIGHT	Access to insurance aim of program. The government would set voluntary minimum standards for private health insurance plans. Those who purchase insurance meeting standards would get tax credits on federal income tax ranging from 10 to 90¢ of the premium, depending on income. Those too poor to pay income tax would get governmental voucher to pay for their insurance.	No person being exempt from the 1¢ tax on earned income would tend to give an equality of participation that is unfortunately threatened by the co-insurance and deductible charges. Graduate students with no earned income and non-resident aliens would not be covered.
PROVISION FOR QUALITY CARE	Peer review by local medical societies only mechanism.	Quality management payments to providers who keep their dollar rate lower than average. PSRO's only other provision for quality control.
PERSONNEL DEVELOPMENT/ DEPLOYMENT: **Manpower** **Research** **Facilities**	No funds—at national level a Health Insurance Advisory Board would determine policy and regulations in relation to carriers of insurance	Health Resources Development Board established with authority to contract for tests and demonstrations. Work closely with state or regional comprehensive health planning agencies (still on congressional drawing board).

Appendix A—Major National Health Insurance Plans(Con'td.)

	Catastrophic Health Insurance and Medical Assistance Reform Act S. 2513 LONG RIBICOFF	Comprehensive Health Insurance Plan H.R. 12684 S. 2970 MILLS SCHNEEBELI PACKWOOD
CONSUMER PARTICIPATION	None	None.
COMPREHENSIVE COVERAGE	Title I: Focus on catastrophic coverage. Same as medicare parts A & B except there is no upper limit on hospital days or home health visits. Title II: Basic health insurance coverage applies to low income persons only. Eligibility is based on income (Limit $4800 for a family of four). Up to 60 days of hospital care; all doctor bills; ancillary services; unlimited nursing home care; prenatal and care up to age 18*; mental health*; family plan.*	All hospital and doctor bills; ancillary services; up to 100 days of post-hospital extended care; 30 days in hospitals for mental health; ambulances; outpatient drugs after $50; 100 days of home health services*; well-child care to age 6 (after $150 deduction); dentistry, vision, hearing services, including hearing aids and glasses, to age 13*; maternity and family planning.*
POSITIVE HEALTH CONCEPT	Under Title I there is no positive health concept. Under Title II those services listed under Comprehensive Services with an (*) are considered preventive.	Basically insurance for illness concept. All services except those above with an (*) in the Comprehensive Coverage Section relate to treatment rather than prevention. There is option of HMO where available.
FINANCING: **Trust Fund;** **Progressive Tax Based on Ability to Pay;** **No Deductibles**	Medical assistance trust fund for Title II established from federal revenues and state contributions equal to current medicaid costs. No deductibles except $3 per visit for first 10 doctors visits. Persons in nursing homes more than 60 days, with no dependents, must contribute all income over $50. An increase of .3¢ in social security taxes finance Title I. Deductibles Titles I & II: After catastrophic coverage, patient pays $17.50 a day and 20¢ of all bills up to $1,000.	No trust fund. Employers pay at least 75¢ of insurance premium, employees the remainder. Federal costs come out of general revenues (persons earning less than $7,500 per year). Deductibles: the first $150 a year in medical bills for each family member up to family limit $450. Patient pays 25¢ of all bills exceeding decutible until out-of-pocket expenses exceed $1500. Adjustments for low income persons.
ACCESS TO HEALTH CARE AS EVERY PERSON'S RIGHT	The Social Security Administration would run the program, using private insurance companies as carriers or intermediates for catastrophic and low-income coverage. HEW sets up *voluntary* guidelines for private health insurance plans, which most persons would purchase as they do now.	Health card ineffective when unpaid bills 90 days in arrears. All employers would have to offer insurance through private companies meeting minimum benefit standards. A federal-state subsidized program would offer the same benefits to the unemployed, the poor, high health risks. Medicare continues expanded. Individuals could choose not to purchase insurance. States would administer program and regulate companies selling insurance.
PROVISION FOR QUALITY CARE	No provisions for quality.	No provision for quality.
PERSONNEL DEVELOPMENT/ DEPLOYMENT: **Manpower** **Research** **Facilities**	No funds for development.	No funds included for development.

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